Musculoskeletal New Patient History *Date:*_____

Patients name: _____ Age:_____ DOB: _____

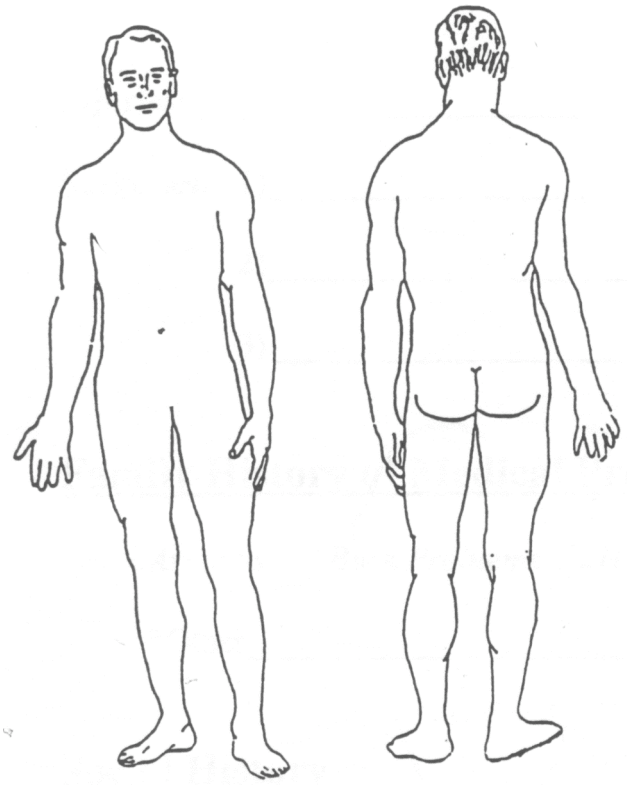
Chief Complaint:_____

When and how did the problem occur?_____

Was this a result of an acute injury or accident?_____

_____

Problem Diagram: Please mark the areas on the diagram where you're experiencing difficulty.



If you have pain please describe the pain sensation. (Circle those that apply)

Aching *Tightness* *Pins & Needles* *Burning* *Stabbing/Sharp*
Shooting *Twisting* *Pressure* *Numbness/Tingling*

When during the day do you have your pain? _____

What makes your pain worse? _____

What makes your pain better?_____

What daily activities does this problem affect? _____

Have you received any special testing or procedures for this problem? (Circle below)

CT Scan MRI EMG X-rays Injections Surgery

Review of Systems

(Circle any symptoms or findings below that you have experienced recently)

Constitutional = weight change, weakness, fatigue, fever, nausea

Eyes = vision problems, double vision

ENMT = hearing problems, dizziness, sinus trouble, sore throat, ringing ears

Cardiovascular = shortness of breath, chest pain, leg swelling, increased blood pressure

Respiratory = cough, coughing up blood, wheezing, asthma

Gastrointestinal = trouble swallowing, heartburn, vomiting, diarrhea, blood or black tar stools

Genitourinary = pain with urination, blood in urine, urgency, incontinence

Musculoskeletal = joint pain/stiffness, cramps, weakness, loss of motion

Skin = rash, lumps, itching, dryness, hair changes, nail changes

Neurological = fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss,headaches

Psychological = nervousness, tension, mood changes, depression, anxiety

Endocrine = heat or cold intolerance, sweating, thirst, changes with hunger

Hematology =bruising, bleeding, transfusion reactions

Hand Dominance= Right_____ Left_____

Past Medical History

Allergies to medications/foods/chemicals? _____

Medication & Supplements List

Medication	**Dosage**	**How often Taken**

Medication & Supplements List

Medication	**Dosage**	**How often Taken**

Supplements	**Dosage**	**How often Taken**

Medical Illnesses (that you have been Diagnosed with: circle those that apply)

Diabetes, Asthma, High Blood Pressure, Heart Attack , Sleep Disorders

Stroke, Stomach Ulcers, Cancer, Heart Murmur, HIV/AIDs, Hepatitis,

Anemia, Seizures, Hyper/Hypo Thyroid, Osteoporosis, Deep Vein Thrombosis,

Osteoarthritis or Rheumatoid Arthritis, Bowel or Bladder Incontinence, Broken Bones

*Other_____

Injuries: _____

(Include broken bones, concussion, motor vehicle accidents, falls etc.)

Surgeries: 1)_____ Date:_____

2)_____ Date:_____

3) _____ Date:_____

Family History of Medical Problems: (Circle those that apply)

Arthritis Back Problems Heart Problems Diabetes Cancer

*Other_____

Social History

Do you exercise? Yes / No

What type? _____

How often and how long? _____

Occupation _____

Hobbies/Interests _____

Do you use Tobacco, Alcohol, or Drugs? If yes, then how often?

_____